UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

AIMEE BEVAN, as Personal Representative of the Estate of Desiree Gonzales, deceased,

Plaintiff,

vs. Case No. 1:15-CV-00073-KG-SCY

SANTA FE COUNTY, MARK GALLEGOS, Deputy Warden/Acting Youth Development Administrator, in his official and individual capacities, GABRIEL VALENCIA, Youth Development Administrator, Individually, MATTHEW EDMUNDS, Corrections Officer, Individually, JOHN ORTEGA, Corrections Officer, MOLLY ARCHULETA, Corrections Nurse, Individually, ST. VINCENT HOSPITAL, and NATHAN PAUL UNKEFER, M.D.,

Defendants.

DEPOSITION OF ROBERT HENRY, M.D.

9:38 a.m.
December 29, 2015
McClaugherty & Silver, P.C.
55 Old Santa Fe Trail
Santa Fe, New Mexico

PURSUANT TO THE NEW MEXICO RULES OF CIVIL PROCEDURE, this deposition was:

TAKEN BY: MR. JOE L. McCLAUGHERTY
Attorney for the Defendant Unkefer

REPORTED BY: Dawn Redwine, RPR, CRI, NM CCR #165
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EXHIBIT
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A. Yes.
Q. And that reading was what you called a, quote, mere, close quote, 89 percent on room air. Do you recall that?
A. Yes.
Q. At the time of that '89 percent, her respiratory rate was not increased. True?
A. Correct.
Q. She had clear breath sounds. True?
A. That is what is recorded, yes.
Q. And she was showing no signs of respiratory distress. True?
A. That's what is recorded by Dr. Unkefer, yes.
Q. Now, you practice in Albuquerque, not in Santa Fe. What do you use as the lower limit of normal at the altitude in Santa Fe for the purpose of O2 sats.?
A. It would be in the low 90s.
Q. Are you aware of what's used in Santa Fe, at 7,000-feet-plus?
A. 92 or so percent was considered normal when I practiced here a long time ago.
Q. When did you last practice in Santa Fe?
A. It was a very long time ago. It was -- It was toward the end of my residency.
Q. But you don't have any idea what it may be in the last 20 years, in terms of the standard in Santa Fe?

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A. I don't -- I wouldn't know why it would change, but the answer to your question is no.
Q. If -- If an oxygen saturation of 89 percent were a sign of respiratory decline, as you suggest, it would get worse, not better, true, if there's a decline occurring?
A. That's too broad of a question for me to answer.
Q. Well, if it's a sign of respiratory decline, by definition, it's declining. True?
A. Of course.
Q. All right. So you would expect it, if it is, in fact, respiratory decline that's being exhibited rather than maybe something else affecting that saturation level, you would expect the following O2 saturations to at least stay the same or continue to decline. Correct?
A. No. The question is not one that I'm able to comprehend because, to me, it's not realistic. The 89 percent oxygen saturation reveals a point in time. It does not point to either improvement or decline, in and of itself.
Q. Isn't it true that, in fact, her oxygen saturations after that 89 percent finding were all normal?
A. Yes.
Q. And isn't it true that all documentation in the medical record and all witness testimony that you may have reviewed show no evidence of respiratory distress in the emergency room on that first admission on May the 7th, 2014?

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A. There is no recording of that, that's correct.
Q. You also have criticism of Dr. Unkefer about the T-sheet that was used. Correct?
A. Yes.
Q. At Presbyterian where you practice, who chooses which T-sheet to use?
A. The physician.
Q. Who fills out the T-sheet at Presbyterian?
A. The physician did.
Q. Do you have scribes at Presbyterian?
A. We do now. We don't use T-sheets anymore. But when we used T-sheets, the physician filled them out.
Q. So you don't even use T-sheets at Presbyterian anymore.
A. That's correct.
Q. Did you replace it with something else?
A. Yes.
Q. What did you replace it with?
A. Electronic medical recording. As per the Healthcare Act, it's mandated.
Q. So factually, in terms of May 7, 2014, in the Emergency Department at St. Vincent's, are you aware who choose the T-sheets?
A. No.
Q. You assumed it was Dr. Unkefer for purposes of your

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opinion. Correct?
A. Yes.
Q. Do you know who fills out the T-sheets at St. Vincent's as of May 7, 2014?
A. I don't know for a fact. I know that there are two separate styles of writing on Desiree's T-sheets, so that means to me that there are two people. My assumption is that a scribe or some other person is writing on the T-sheet in addition to Dr. Unkefer.
Q. Well, are you able to recognize Dr. Unkefer's handwriting on the T-sheet?
A. No, I can't tell. I just know that there are two different people.
Q. But you've assumed that one of them is Dr. Unkefer.
A. Yes.
Q. And have also assumed that -- Were you aware that they have scribes? I'm sorry. Were you even aware that St. Vincent's had scribes in the Emergency Department?
A. Yes.
Q. So did you assume that one of the other persons writing on the T-sheet was a scribe?
A. Yes.
Q. But you have no way of knowing who wrote what on that T-sheet on May 7, 2014. True?
A. That's correct.

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basis. Correct?
A. That's only in part. The rest of it is the time frame. To give Ativan, as I said in my report, as soon as it was given was inappropriate and dangerous. Those aren't the exact words I use, but that's what I was conveying, trying to convey.
Q. You then talk about, in your report, that Dr. Unkefer didn't discuss the use of Ativan with the patient or anyone else associated with her care, like police or parents. Do you recall that?
A. Yes.
Q. Well, her parents weren't there. True?
A. Correct.
Q. And the police don't have any authority to make a decision about medical treatment, do they?
A. No.
Q. And there is a consent to treatment on file for her, isn't there, in the medical record?
A. That was -- I have not seen it.
Q. Okay. Well, should they not treat a 17-year-old heroin overdose patient if the parents don't show up?
A. No, they should. I think it would have been appropriate to have told her that they were giving her some medication to calm her down, but I'm not -- I'm not going to overaccentuate that process.

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Q. And you don't know whether Dr. Unkefer did or did not tell her what he was going to do as he did it.
A. I do not.
Q. And do you know the policy and procedure of the nurses at St. Vincent's is always to tell the patient before they push the meds what they're doing?
A. That was my assumption. It is my assumption that that would be a policy and procedure. That's why I mentioned it in my report.
Q. Do you agree that a vast majority -- or at least most heroin overdose patients that are reversed with Narcan have multiple central nervous system depressants in their system?
A. No.
Q. Do you agree that the medical literature which supports a two-hour observation period after the administration of Narcan includes the considerations of other CNS depressants in the system of recipients of Narcan?
A. Oh, yes.
Q. Isn't it true that when the Narcan wears off, the physicians and other healthcare professionals have any other medications, drugs, anything that might be in the system, front and center for evaluation?
A. If you could repeat that.
Q. Sure.

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A. You trailed off at the end.
Q. Yeah. When the Narcan wears off, the healthcare professionals treating the patient have all other intoxicants in that patient that kind of come out front and center once the Narcan is gone. True?
A. I don't understand what you mean.
Q. Well, if there's things underlying it that the Narcan is suppressing, once it wears off, those things then present themselves for evaluation by the healthcare professionals. True?
A. They may, depending upon the time interval.
Q. Well, Ativan kicks in quickly. Correct?
A. It does, relatively quickly.
Q. Peaks at about an hour. True?
A. That's correct.
Q. And it doesn't get more effective after it peaks. Correct? It, instead, decreases in effectiveness after it peaks.
A. In general, that's true, but it's -- it's different in everybody. Its effects, as with other medications, are different in everybody.
Q. Well, by definition, after it peaks, it has to diminish. True?
A. Yes, but it doesn't peak at one hour in everybody all the time. It's variable.

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Q. Right, but it certainly is going to peak within the accepted medical standard that Dr. Fisher testified to, between half an hour and 90 minutes. True?
MR. HUNT: Object to the form.
A. In general, I think that's true, but truly it -- when it peaks is variable.
Q. And you -- I'm sorry.
A. Well, it -- I have seen that. I mean, this is -- this is a medication -- these are two medications that I use, utilize in the ER, four or five times a week in a different -- for other than sedation of agitation. I use them for procedural sedation. And what I'm attempting to convey here is that since I use them so much, I know that I can never predict how soon they're going to take effect, and, more importantly, I can never predict how long they're going to last. It's different in everybody. We all metabolize differently.
Q. Well, isn't that why, though, they set the standard that they set for Narcan in terms of the studies that are done, that that's its effective period? It's based on a general population. Correct?
A. Yes, but I'm not sure I understand the question.
Q. Well, the half-an-hour-to-90-minute effectiveness of Narcan is based on a general application to the population as a whole. Correct? It includes the outliers that you're talking about on both ends of the spectrum. Right?

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Well, I know I didn't --
MR. HUNT: Just answer the question. Ignore head nods.
A. 41 years doing this and using these medications multiple times a week and seeing these kinds of patients multiple times and knowing what, at the very least, can happen metabolically and knowing logically what does happen metabolically, meaning that they have to have a significant period of time of observation before they're safe to be discharged.
Q. How long do you keep patients when you're treating them in the ER at Pres after the administration of Narcan? You, personally.
A. Two to three hours. Of course, that's not this case, but that's -- that's a separate case. That's a heroin overdose, you're talking about, who's been given Narcan.
Q. And how long do you keep this case, a heroin overdose who's been given Narcan, who's also had some other type of central nervous system depressant given in the ER?
A. Hours.
Q. How many hours?
A. Whatever it takes to know that they are safe. It's whatever that number is, is based upon her presentation and knowledge of what these medications do metabolically.
Q. Okay.

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A. So I could tell you five hours or I could tell you eight hours. It depends on how she's responding. If in six hours her heart rate is now 72, she's awake, alert and oriented, and not wobbling about the room as she was at the intake at the jail, but acting completely normally, then I would certainly consider discharge to a safe environment. So I can't give you an actual number of hours, but I know it's considerably longer than an hour and 12 minutes.
Q. Well, do you have a protocol at Presbyterian, a written protocol on how long you keep patients who heroin overdose with Narcan that are given any other central nervous system depressant?
A. We do, and --
Q. And is it in writing?
A. Yes.
Q. Okay. Did you bring it with you?
A. No.
Q. Okay. What's it say?
A. It says that -- First of all, it identifies heroin overdose and necessitation of Narcan reversal is a significant life-threatening event. And then it does not -- And I helped write this, but that's irrelevant. It's just why I know it so well.
It doesn't put a specific number on hours. It talks about -- It -- It says that clinical judgment has to be

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used. And what "clinical judgment" means is all the things we've just discussed, and that's observation for a long enough period of time to know that the patient is safe. And an hour-and-12-minute discharge from a heroin overdose with administration of Narcan and then administration of IV Ativan would be perceived by reviewers at the hospital where I work as to be poor clinical judgment.
Q. Well, you did not exercise any clinical judgment in Ms. Gonzales' case. True?
A. Again, that's a constant.
Q. I'm just making sure that it's clear on the record.
A. Okay.
Q. And you're not bringing clinical judgment to this testimony, either, because you never saw the patient. True?
A. Well, of course I'm bringing clinical judgment to it. That's what the case is all about.
Q. Well, no. You're bringing expert testimony after the fact of the case, when you know the outcome of the case, not clinical judgment based on seeing the patient at the time. True?
MR. HUNT: Object to the foundation.
A. Well, no. In my opinion, I am bringing clinical judgment. I am saying that clinical judgment was -- reasonable clinical judgment was not utilized in her premature discharge from the emergency room.

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Q. Okay. The recognized standard of care for emergency room discharge post Narcan patient for heroin overdose is one to two hours of post Narcan administration. True?
A. No. I think it would be more like two to three, but it doesn't matter because that's not this case.
Q. Well, that's where I'm starting from. Do we agree or not that the vast majority of medical literature on this topic says that the standard of care for an emergency room post Narcan discharge of a heroin overdose patient is one to two to three hours?
A. I'm not saying one hour. I would say two to three.
Q. I've got medical authorities that say one hour.
A. And it's the point that we made with respect to the medical literature. We can find just about whatever we want in the medical literature. Standard of care in our area, which would include Santa Fe and Albuquerque, for a Narcan reversal, heroin overdose, is two to three hours.
Q. Now, that standard in terms of heroin overdose, Narcan, was created to include the possibility of other drugs in the system, including central nervous system depressants. True?
A. No. We are talking about simply heroin overdose.
Q. But, Doctor, you know, as a clinical physician, that there are going to be many times that someone who is using

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observation period beyond the standard-of-care time. I haven't heard a single reference to amount of time, and I'm just waiting to see if you're going to give me that. But you take your time. Give me everything you want to give me out of Exhibit 77.

A. So you're looking for a specific time period, and I have been saying that the answer is clinical judgment and that there is no specific time period, that the knowledge that these two drugs potentiate each other and accentuate respiratory depression when used together is a known fact; and, therefore, logically, a long period of time has to be utilized in observation. And in this case, a long period of time was not utilized. I don't think anybody could possibly say an hour and 12 minutes was a long period of time.

Q. Well, she was actually observed from the time -- by medical professionals from the time of the administration of Narcan until the discharge from the hospital. True?

A. But I'm talking about in the ER.

Q. Yeah, but in terms of total observation time, it exceeded two hours. Correct?

A. As far as medical personnel is concerned, yes.

Q. And that's the standard with Narcan, two hours with medical personnel. Correct? Doesn't have to be in the Emergency Department.

A. Two to three hours for Narcan alone.

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Q. Well, I'm asking -- I'm telling you, here is your opportunity. Tell me in Exhibit 77 if there's anything in there that supports your claim about an extended period of observation after the addition of Ativan.

A. We're not going to find a specific time period. We're -- We're -- These papers are telling us that these two drugs potentiate each other and they stick around a long time and, therefore, the person has to be watched for a long period of time.

I -- I don't know that anybody would be so brazen as to say that the time period has to be 5.5 hours, because if that's in the literature, then that could be utilized. Nobody is going to say that. They're going to talk about clinical judgment with the knowledge of, well, pharmacologically, physiologically, metabolically what these drugs do.

Q. All right. You agree with me, don't you, that the other Plaintiff's expert, Dr. Fisher, knows a lot more than you do about interaction of the drugs heroin, Narcan, and Ativan? True?

A. Yes. He's a toxicologist.

Q. And did you review Exhibit 63 that was presented by him in support of his opinions in this case?

A. Yes.

MR. HUNT: What is it?

MR. McCLAUGHERTY: The "Recurrent opioid toxicity

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after pre-hospital care of presumed heroin overdose patients."

MR. HUNT: Who is the author?

MR. McCLAUGHERTY: Boyd.

MR. HUNT: Okay.

Q. And that Conclusion of that article presented by Dr. Fisher was "Allowing presumed heroin overdose patients to sign out after pre-hospital care with naloxone is safe. If transported to an emergency department, a one-hour observation period after naloxone administration seems to be adequate for recurrent heroin toxicity."

Did you see that?

A. Yes, I did, and that article talks about heroin only.

Q. No, I'm talking about the one-hour observation period if he goes to an ED. Are you with me on that so far?

A. For opioid only.

Q. All right. Well, then if you want to -- I'll just use Exhibit 64, also presented by Dr. Fisher, who you recognize has more experience than you in this area, where it specifically addresses this question of opioid toxicity recurrence after an initial response to naloxone. And it says in there that "Recurrence of toxicity was more common with long-acting opioids." Heroin is not. Correct? Do you agree heroin is not a long-acting opioid? It's a short-acting opioid. True?

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A. Heroin -- Pure heroin is. But, again, we don't know what else is utilized.

Q. Well, the article says heroin is a short-acting opioid. Do you disagree with the article?

A. No, I don't disagree with that, but that's why heroin is cut with things that last longer. It's not lucrative or safe for a drug dealer to use pure heroin, because it does last a short period of time. In any case, this article says nothing about the concomitant use of benzodiazepine.

Q. Actually, it does. I'm getting there.

MR. HUNT: Object to the form.

Q. Exhibit 64. It goes "Recurrence of toxicity was more common with long-acting opioids." And to answer your point, you don't have any idea what was in the heroin that Ms. Gonzales took, do you?

A. Correct.

Q. Okay. "Recurrence of toxicity was more common with long-acting opioids, and was not associated with the route of opioid exposure" -- that's IV or some other way -- "or presence of ethanol and other CNS depressants."

A. I am -- I am familiar with that.

Q. Right. And Ativan is a CNS depressant. True?

A. Yes.

Q. So in this study done in the Journal of Clinical Toxicology --

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A. Yes.
Q. -- put forward by Dr. Fisher, who is on your side of this case, it says that there is no recurrence of toxicity that can be proven even with other CNS depressants onboard the patient. True?
MR. HUNT: Object to the foundation.
A. I am aware of that article. Yes.
Q. So that does say something that completely disagrees with your point, doesn't it?
MR. HUNT: Object to the foundation.
A. I pondered that article a great deal, and I think reading it, as you have, does put it out of context. My interpretation of that is that that is certainly not a guideline that is accepted practice. In other words, it is not a reason to allow people to be discharged in a short period of time who have had concomitant use of benzodiazepine and opiate.
Q. This article is inconsistent with your opinion. True?
MR. HUNT: Object to the foundation.
A. May I take a look at the article again? I have it here, as well.
The bottom line is the last paragraph of the article, which states that "The results of this evaluation" -- the study -- "suggest that the frequency of opioid toxicity recurrence is approximately 20 to 45 percent after an initial

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response to naloxone. While recurrence of toxicity is more frequent with long-acting opioids, it also all occurs with short-acting opioids, including heroin and codeine. There were no clinically useful predictors of which patients would have recurrence of toxicity after an initial response to naloxone."
So what the summation is, is that it certainly doesn't give a time period which is safe. It again puts us back into the clinical judgment arena.
Q. That article is inconsistent with your opinion, isn't it?
MR. HUNT: Object to the foundation.
A. Well, no, I don't think it is inconsistent.
Q. The conclusions expressed in that article, Exhibit 64, are inconsistent with your claim as to the Ativan being a contributor to the outcome in this case. True?
MR. HUNT: Object to the foundation.
A. I do not believe that's what the author is saying.
Q. All right. Have you read or are you familiar with the Journal of Toxicology: Clinical Toxicology?
A. It's not a journal that I read, no.
Q. Do you recognize it as an authoritative journal?
A. I don't know anything about the Journal of Toxicology.
Q. Have you read the article "Do Co-intoxicants Increase Adverse Event Rates in the First 24 Hours in Patients

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Resuscitated from Acute Opioid Overdose?"
A. If I may see the article and see if I've read that.
MR. McCLAUGHERTY: Counsel, that is my copy.
MR. HUNT: Yeah. I won't write on it or flag it or anything.
MR. McCLAUGHERTY: All right.
MR. HUNT: And I will return it, as well.
MR. McCLAUGHERTY: All right.
MR. HUNT: Thank you.
MR. McCLAUGHERTY: Thanks.
A. I see the article. I had not read that article.
Q. Okay. This article -- The Conclusion in this article is that "In patients resuscitated from acute opioid overdose, short-term outcomes are similar for patients with pure opioid overdose and multidrug intoxications. A history of co-intoxication cannot be used to identify high-risk patients who require more intensive Emergency Department monitoring or prolonged observation."
A. Yes, I read that.
Q. It's inconsistent with your opinion. True?
MR. HUNT: Object to foundation.
A. It is.
Q. In fact, the study itself goes on to state in the body of it that to the knowledge of the authors. "this is the first study to assess the impact of co-intoxicants as

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predictors for the occurrence of short-term adverse events in patients who have been resuscitated from acute opioid overdose."
Did you note that in there?
A. Yes.
Q. And it says "Unlike postmortem studies, this study suggests that co-intoxicants do not increase the risk of short-term adverse events in survivors of opioid overdose."
That's inconsistent with your opinion. True?
A. It is.
Q. I'm going to mark this one as 84.
MR. McCLAUGHERTY: Counsel, I apologize. It's got the highlighting. If you're troubled by that at all, I can get a clean copy to substitute in, but it is highlighted as he was looking at it, so your call.
MR. HUNT: Okay. We'll leave it for now and take a look. Let me just see it.
MR. McCLAUGHERTY: Okay.
(Exhibit 84 marked for identification.)
Q. Doctor, define for me what you mean when you say benzodiazepines are non-competitive inhibitors of opiate metabolism.
A. What it means is that the site in the brain where opiates are broken down is altered by benzodiazepine. And the non-competitive part just means that it's independent of